PRINTED: 05/18/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G464	(X2) MU A. BUII B. WIN	LDING G	ONSTRUCTION 00	СОМ 04/ 1	TE SURVEY IPLETED 18/2012	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 2414 WOODLANE MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG W0000	PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE	
	#IN00106203. COMPLAINT #IN SUBSTANTIATE! deficiencies related W102, W104, W12 W159. Dates of survey: A Facility number: 0 Provider number: 1 AIM number: 1002 Surveyor: Tim Should the following defindings in accordance.	D, Federal and state I to the allegation(s) are cited at 22, W124, W149, W153, and April 16, 17, and 18, 2012 00978 5G464 249370 ebel, Medical Surveyor III ciencies also reflect state nce with 460 IAC 9. appleted on April 19, 2012 by	Woo	000				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G464			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/18/2012	
	PROVIDER OR SUPPLIER		5	STREET A	ADDRESS, CITY, STATE, ZIP CODE OODLANE LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	(X5) COMPLETION DATE
W0102	The facility must governing body a requirements are Based on record Condition of Par Body and Manag facility's governi implement polici assure 1 of 3 sam hygiene and pers addressed by Dir Service Coordina Retardation Professional Findings include 1. Please refer to governing body if policies and proceduce an	review and interview, the ticipation of Governing gement is not met as the ng body failed to es and procedures to apled client's (client A's) onal needs were timely ect Care Staff and the ator (Qualified Mental essional.) : O W104 as the facility's failed to implement edures to address the fand the Service roviding, monitoring, and	W0	102	Staff will be retrained on assis with client's hygiene and care Should an issue arise, staff is notify Service Coordinator immediately. Service Coordinator will then take the necessary actions to make sure the issue taken care of in a timely manner To ensure future compliance, Service Coordinator will make random visits to observe hygie practices at least monthly.	to ator e is ner.	05/01/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZG8611

Facility ID: 000978

If continuation sheet

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	IT OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: 15G464	(X2) MULTIPLE CO A. BUILDING B. WING	00	СОМ 04/1	E SURVEY PLETED 8/2012
	ROVIDER OR SUPPLIER		STREET A 2414 W MERRII	DE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE

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Event ID: ZG8611

Facility ID: 000978

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G464	B. WING		04/18/2012
NAME OF	PROVIDER OR SUPPLIE	R	STREET	ADDRESS, CITY, STATE, ZIP CODE	
				VOODLANE	
ARC OF	NORTHWEST IND	DIANA INC, THE	MERRI	LLVILLE, IN 46410	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
W0104	483.410(a)(1) GOVERNING B	ODV			
		oody must exercise general			
policy, budget, and operating direction ov					
	the facility.	. 0			
	Based on record	review and interview, the	W0104	All incidents are to be reported	05/01/2012
		ing body failed to		within 24 hours. Staff will be retrained on all incident report	ing
implement policies and procedures which			procedures. To ensure future	1119	
	addressed the Direct Care Staff a			compliance, Service Coordina	III
		ator (Qualified Mental		will monitor all incident reports	
	Retardation Pro	fessional) in providing,		completion. Phone calls will be	
monitoring, and co		coordinating timely care		made weekly to group home to inquire about any incidents for	
	of 1 of 3 sample	d client's hygiene and		past week.	
	personal needs (client A).			
	Findings include	e:			
	A review of the	facility's incident reports			
	on 4/16/12 at 9::	52 A.M., from 3/1/12 to			
	4/16/12, indicate	ed the following incident			
	of neglect which	n involved client A:			
	"Date: 3/26/201	2, Name: [Client A],			
	Narrative: [Clie	ent A's] sister visited			
	[client A] on 3/2	25/12 and discovered			
	bruises on her (c	client A's) body; feces			
	under her finger	nails; extremely dry			
	skin; and toe nat	ils so long they were			
	upturned. Staff	(direct care staff) said			
	_	A) has an appointment			
	with the podiatri	ist once in every six			
	1	guardian does not have			
	any records of a	podiatry appointment.			
	1 -	Agency will take			
		y measures to ensure			
	[client A's] healt				

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	OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G464	A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL 04/18/	ETED
		100101	B. WIN		DDRESS, CITY, STATE, ZIP CODE	0 17 107	2012
NAME OF PR	OVIDER OR SUPPLIER				OODLANE		
ARC OF N	ORTHWEST INDI	ANA INC, THE			LVILLE, IN 46410		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The facility's reco	ords were further					
	•	5/12 at 10:10 A.M The					
facility's investigative report of the 3/25/12 incident report indicated the							
		stigation was conducted					
	•	All staff was (sic.)					
		oved from the home					
	•	ts of the investigation					
		staff trained and put into					
	•	e. The results of the					
	•	as follows: [Client A's]					
	-	ho are co-guardians of					
	• `	ctures on Sunday March					
	, .	pm of a mark on [client					
		the facility) received					
		n Monday March 26,					
		via email. Two separate					
	•	sments were performed					
		ne Director of Health					
	•	oth nurses stated in the					
	investigation and	upon follow-up with the					
	department head	that there was no					
	swelling of the ha	ands noticed, nor was a					
	bruise noted on [client A's] abdomen.					
	The only skin dis	scoloration noted was an					
	approximate dim	e size very light pink					
	area to her (clien	t A's) lower buttock.					
	[Client A] was th	en assessed by the					
	doctor. The doct	or did not notice any					
	injuries or swelli	ng at the time of visit.					
	Additional pictur	res of long toe nails and					
	dirty finger nails	were also included. The					
	family cut [client	t A's] toe nails and					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G464	B. WING		04/18/2012
NAME OF I	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	
				/OODLANE	
ARC OF	NORTHWEST IND	IANA INC, THE	MERRI	LLVILLE, IN 46410	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	_	er nails at about 8:30 pm			
	on Sunday 3/25/12. Risk plans will also				
	_	are of nails for the			
	consumer. The	investigation was			
	concluded and the	ne allegation			
	substantiated. D	iscipline was rendered,			
	four staff had di	rect knowledge of [client			
	A's] toe nails and	d their employment at the			
	[Agency] was te	rminated. The remaining			
	staff did not wor	k shifts which involved			
	bathing or dressi	ing and had no direct			
	knowledge of the	e condition of [client A's]			
	toe nails or the p	oink dime size mark but			
	_	tional training in regards			
		nd care. New staff are in			
		trained to work with			
	-	nt A] also visited a			
		indicated that there was			
	*	ed by [client A's] feet			
	from her long to				
	nom ner long to	e nans.			
	The facility's rec	ords were further			
		6/12 at 10:22 A.M			
		the 3/30/12 investigation			
		graphs of client A's body,			
		n by client A's guardian			
		Forwarded to the facility.			
		notographs indicated dirt			
	-	fingernails which was			
		e feces. Client A's toe			
		to be of varied length			
		ch to an inch and were			
	-	me size pink mark was			
	noted on client A	A's buttocks and a pencil			

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Event ID: ZG8611

Facility ID: 000978

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NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ARE BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2414 WOODLANE MERRILLVILLE, IN 46410 (X5)		OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO.	NSTRUCTION	COMPL	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE SUMMARY STATEMENT OF DEFICIENCIES TAG PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Facility records were further reviewed on 4/16/12 at 10:31 A.M Review of evidentiary documentation indicated direct care staff working at the time of the incident did not consider the length of client A's toe nails to be "uncommon." Further review indicated direct care staff did not immediately report the dime size pink mark on client A's family told the facility's service Coordinator (Qualified Mental Health Professional) on the morning of 3/25/12 of the excessive length of client A's toe nails, dime size pink mark, and pencil size blood blister, and feces under the client's fingernails. Review of the Service Coordinator did not take any	AND PLAIN	OF CORRECTION				00		
ARC OF NORTHWEST INDIANA INC, THE ARC OF NORTHWEST INDIANA INC, THE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY PULL. TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Facility records were further reviewed on 4/16/12 at 10:31 A.M Review of evidentiary documentation indicated direct care staff working at the time of the incident did not consider the length of client A's toe nails to be of excess length and did not consider the dirt under the client's finger nails to be "uncommon." Further review indicated direct care staff' did not immediately report the dime size pink mark on client A's buttocks and the pencil eraser size blood blister on the client's finger to the facility's administrator. Additional review indicated client A's family told the facility's Service Coordinator (Qualified Mental Health Professional) on the morning of 3/25/12 of the excessive length of client A's toe nails, dime size pink mark, and pencil size blood blister, and feces under the client's fingernails. Review of the Service Coordinator's investigative interview indicated the Service Coordinator did not take any			100101	B. WIN		PPPPGG GYMY GM :	U 4 / 10/	20 IZ
ARC OF NORTHWEST INDIANA INC, THE (X4) ID SUMMARY STATEMENT OF DEPCIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION) Fracility records were further reviewed on 4/16/12 at 10:31 A.M Review of evidentiary documentation indicated direct care staff working at the time of the incident did not consider the length of client A's toe nails to be of excess length and did not consider the dirt under the client's finger nails to be "uncommon." Further review indicated direct care staff did not immediately report the dime size pink mark on client A's buttocks and the pencil craser size blood blister on the client's finger to the facility's administrator. Additional review indicated client A's toe nails, dime size pink mark, and pencil size blood blister, and feces under the client's fingernails. Review of the Service Coordinator's investigative interview indicated the Service Coordinator did not take any	NAME OF P	PROVIDER OR SUPPLIER						
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) eraser size dark blue blood blister was noted on a fingernail. Facility records were further reviewed on 4/16/12 at 10:31 A.M Review of evidentiary documentation indicated direct care staff working at the time of the incident did not consider the length of client A's toe nails to be of excess length and did not consider the direct care staff did not immediately report the dime size pink mark on client A's buttocks and the pencil eraser size blood blister on the client's finger to the facility's administrator. Additional review indicated client A's toe nails to do the morning of 3/25/12 of the excessive length of client A's toe nails, dime size pink mark, and pencil size blood blister, and feecs under the client's fingernails. Review of the Service Coordinator's investigative interview indicated the Service Coordinator did not take any	ARC OF	NORTHWEST INDI	ANA INC, THE					
TAG REGULATORY OR LSC DENTIFYING INFORMATION) eraser size dark blue blood blister was noted on a fingernail. Facility records were further reviewed on 4/16/12 at 10:31 A.M Review of evidentiary documentation indicated direct care staff working at the time of the incident did not consider the length of client A's toe nails to be of excess length and did not consider the dirt under the client's finger nails to be "uncommon." Further review indicated direct care staff did not immediately report the dime size pink mark on client A's buttocks and the pencil eraser size blood blister on the client's finger to the facility's administrator. Additional review indicated client A's family told the facility's Service Coordinator (Qualified Mental Health Professional) on the morning of 3/25/12 of the excessive length of client A's toe nails, dime size pink mark, and pencil size blood blister, and feces under the client's fingernails. Review of the Service Coordinator's investigative interview indicated the Service Coordinator did not take any		SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
eraser size dark blue blood blister was noted on a fingernail. Facility records were further reviewed on 4/16/12 at 10:31 A.M Review of evidentiary documentation indicated direct care staff working at the time of the incident did not consider the length of client A's toe nails to be of excess length and did not consider the dirt under the client's finger nails to be "uncommon." Further review indicated direct care staff did not immediately report the dime size pink mark on client A's buttocks and the pencil eraser size blood blister on the client's finger to the facility's administrator. Additional review indicated client A's family told the facility's Service Coordinator (Qualified Mental Health Professional) on the morning of 3/25/12 of the excessive length of client A's toe nails, dime size pink mark, and pencil size blood blister, and feces under the client's fingernails. Review of the Service Coordinator's investigative interview indicated the Service Coordinator did not take any		`				CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
noted on a fingernail. Facility records were further reviewed on 4/16/12 at 10:31 A.M Review of evidentiary documentation indicated direct care staff working at the time of the incident did not consider the length of client A's toe nails to be of excess length and did not consider the dirt under the client's finger nails to be "uncommon." Further review indicated direct care staff did not immediately report the dime size pink mark on client A's buttocks and the pencil eraser size blood blister on the client's finger to the facility's administrator. Additional review indicated client A's family told the facility's Service Coordinator (Qualified Mental Health Professional) on the morning of 3/25/12 of the excessive length of client A's toe nails, dime size pink mark, and pencil size blood blister, and feces under the client's fingernails. Review of the Service Coordinator's investigative interview indicated the Service Coordinator did not take any	TAG		·		TAG	DEFICIENCY)		DATE
Facility records were further reviewed on 4/16/12 at 10:31 A.M Review of evidentiary documentation indicated direct care staff working at the time of the incident did not consider the length of client A's toe nails to be of excess length and did not consider the dirt under the client's finger nails to be "uncommon." Further review indicated direct care staff did not immediately report the dime size pink mark on client A's buttocks and the pencil eraser size blood blister on the client's finger to the facility's administrator. Additional review indicated client A's family told the facility's Service Coordinator (Qualified Mental Health Professional) on the morning of 3/25/12 of the excessive length of client A's toe nails, dime size pink mark, and pencil size blood blister, and feces under the client's fingernails. Review of the Service Coordinator's investigative interview indicated the Service Coordinator did not take any								
4/16/12 at 10:31 A.M Review of evidentiary documentation indicated direct care staff working at the time of the incident did not consider the length of client A's toe nails to be of excess length and did not consider the dirt under the client's finger nails to be "uncommon." Further review indicated direct care staff did not immediately report the dime size pink mark on client A's buttocks and the pencil eraser size blood blister on the client's finger to the facility's administrator. Additional review indicated client A's family told the facility's Service Coordinator (Qualified Mental Health Professional) on the morning of 3/25/12 of the excessive length of client A's toe nails, dime size pink mark, and pencil size blood blister, and feces under the client's fingernails. Review of the Service Coordinator's investigative interview indicated the Service Coordinator did not take any		noted on a finger	naıl.					
and did not report the noted pink mark on the client's buttocks or the blood blister on the client's finger to the administrator until approached by the facility's administration on 3/27/12.		Facility records of 4/16/12 at 10:31 evidentiary document did not considered and did not considered from the client's finger national from the client's finger national from the client's finger national from the client's finger to a dministrator. A findicated client of administrator. A findicated client of facility's Service Mental Health Promorning of 3/25/length of client of pink mark, and pand feces under the Review of the Service Coordinate action to have client's findicated cli	were further reviewed on A.M Review of mentation indicated working at the time of the consider the length of ls to be of excess length ider the dirt under the ils to be "uncommon." indicated direct care staff rely report the dime size ent A's buttocks and the blood blister on the the facility's dditional review A's family told the Coordinator (Qualified rofessional) on the 12 of the excessive A's toe nails, dime size encil size blood blister, the client's fingernails. Ervice Coordinator's erview indicated the ator did not take any tent A's toe nails trimmed at the noted pink mark on each or the blood blister ager to the administrator by the facility's					

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL	
		15G464	A. BUI B. WIN	LDING G		04/18/	2012
NAME OF I	PROVIDER OR SUPPLIER		р. W II V		ADDRESS, CITY, STATE, ZIP CODE		
					OODLANE		
ARC OF	NORTHWEST INDI	ANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		erviewed on 4/17/12 at					
	9:12 A.M Nurs	se #1 stated client A's toe					
	nails "were so lo	ng that she (client A)					
curled her toes down so she could wear							
her shoes."							
	•	r #1 was interviewed on					
		A.M Program Director					
	· ·	direct care staff and the ator were found guilty of					
		re terminated." Program					
	_	d direct care staff and the					
		ator "should have					
		riate care to [client A]					
		reported the pink mark					
	and the blood bli	ster immediately to the					
	administrator. A	s an agency we train and					
		ake care of our clients in					
		s. We expect and trust					
		jobs. It isn't always easy					
	to determine who	en they aren't."					
	This fodomal too	valatas ta aammilaint					
	#IN00106203.	relates to complaint					
	π 11100100203.						
	9-3-1(a)						
	<i>y</i> 2 - (u)						

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G464	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 04/1	TE SURVEY SPLETED 18/2012		
ARC OF	ROVIDER OR SUPPLIE	DIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2414 WOODLANE MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION ULD BE PROPRIATE	(X5) COMPLETION DATE		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G464	B. WIN	G		04/18/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					VOODLANE		
ARC OF	NORTHWEST INDI	ANA INC, THE		MERRI	LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
W0122	483.420 CLIENT PROTE	CTIONS					
		ensure that specific client					
		rements are met.					
	Based on record	review and interview, the	W0	122	All incidents of abuse, neglect	t, or	05/01/2012
		ticipation of Client			exploitation will be reported w	ithin	
		t met as the facility failed			24 hours. To ensure future		
		e guardian of 1 of 2			compliance, Service Coordina will make random visits to the		
	<u> </u>	with a guardian (client A)			house at least twice monthly t		
	-	pointments for treatment;			observe hygiene practices, ar	nd to	
		·			ensure client's needs are beir	ng	
2. Implement it's abuse/neglect policy to assure the personal needs of 1 of 3					met.		
sampled clients (client A) were addressed,							
		ent it's abuse/neglect					
	_	eviewed incident of					
		own origin involving 1 of					
	3 sampled clients	•					
	_	orted to the administrator;					
		ne Service Coordinator					
	(Qualified Menta						
	` ~	onitored and coordinated					
	· · · · · · · · · · · · · · · · · · ·						
	*	of 3 sampled clients					
	`	ene, personal, and					
	medical needs.						
	Findings include	:					
	1 101	W/104 /1 C '11'					
		W124 as the facility					
	1	of 2 sampled clients					
		client A) of impending					
	medical appointr	nents.					
		W149 as the facility					
	neglected to imp	lement it's abuse/neglect					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G464			A. BUILDING B. WING			COMPLETED 04/18/2012	
	PROVIDER OR SUPPLIER		p. why	STREET A	ODLANE LVILLE, IN 46410		
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E.	(X5) COMPLETION DATE
	policy to assure to 3 sampled clients addressed and im administrator of of injuries of unktof 3 sampled clients. 3. Please refer to 3.	he personal needs of 1 of s (client A) were amediately notify the 1 of 1 reviewed incident known origin involving 1 onts (client A.)					
	failed to implement it's abuse/neglect policy to 1 of 1 reviewed incident of injuries of unknown origin involving 1 of 3 sampled clients (client A) were immediately reported to the administrator.						
	4. Please refer to W159 as the facility failed to assure the Service Coordinator (Qualified Mental Retardation Professional) monitored and coordinated timely care for 1 of 3 sampled clients (client A's) hygiene, personal, and medical needs.						
	This federal tag r #IN00106203. 9-3-2(a)	relates to complaint					

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G464	(X2) MULTIPLE CC A. BUILDING B. WING	00	— COM	TE SURVEY MPLETED 18/2012		
	ROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 2414 WOODLANE MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G464			LDING	ONSTRUCTION 00	(X3) DATE : COMPL 04/18/	ETED	
	PROVIDER OR SUPPLIER		p. why	STREET A	ADDRESS, CITY, STATE, ZIP CODE COODLANE LLVILLE, IN 46410	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
W0124	The facility must clients. Therefore each client, pare legal guardian, or condition, develor status, attendant the right to refuse Based on record facility failed to relients with a guardian medical impending medical findings include. Client A's record 4/16/12 at 10:10 client's cumulative indicated the client appointment with physician on 3/20 podiatrist appointment with physician on 3/20 podiatrist appointment in legal co-guardiant client's sisters. Program Director 4/17/12 at 9:15 Are client A's guardiant the primary care appointments, Prestated, "No."	review and interview, the notify 1 of 2 sampled ardian (client A) of cal appointments. : was reviewed on A.M A review of the we medical record	W0	124	Service Coordinator will notify clients and their legal guardial of any changes in physical, medical, and behavioral condition. To ensure future compliance, Service Coordina will visit clients weekly, and w make contact with the legal guardians at least monthly.	ns	05/01/2012

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G464		A. BUILDING B. WING				
	PROVIDER OR SUPPLIE		STREET A 2414 W MERRII			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TI DEFICIENCY	CORRECTION ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
	#IN00106203.					
	9-3-2(a)					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE C	ONSTRUCTION	l í	E SURVEY PLETED
AND PLAN	OF CORRECTION		A. BUI	LDING	00		
		15G464	B. WIN			04/10	8/2012
NAME OF	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
ABC OF	NODTHWEST IND	IANIA INIC. THE			VOODLANE		
	NORTHWEST IND			MERK	ILLVILLE, IN 46410		_
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, and the second	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	COMPLETION
TAG W0149	483.420(d)(1)	LISC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCT		DATE
VVU 149		MENT OF CLIENTS					
		develop and implement					
		and procedures that prohibit					
		eglect or abuse of the client.	1	1.10			0.5/0.1/2.010
	Based on record review and interview, the		W0	149	The agency policy for Abus		05/01/2012
		d to implement it's			Neglect, and Exploitation w followed at all times. To en		
		buse/neglect policy to assure the			future compliance, Service	··· -	
	1 -	of 1 of 3 sampled clients			Coordinator will report any		
	(client A) were a				incidences that could be		
	1	ify the administrator of 1			considered abuse, neglect, exploitation to Residential	or	
	of 1 reviewed in	cident of injuries of			Program Director.		
	unknown origin	involving 1 of 3 sampled					
	clients (client A.	.)					
	Findings include	2 :					
	A review of the	facility's incident reports					
	on 4/16/12 at 9:5	52 A.M., from 3/1/12 to					
	4/16/12, indicate	ed the following incident					
	of neglect which	involved client A:					
	"Date: 3/26/201	2, Name: [Client A],					
	Narrative: [Clie	nt A's] sister visited					
	[client A] on 3/2	5/12 and discovered					
	bruises on her (c	elient A's) body; feces					
	under her finger	nails; extremely dry					
	skin; and toe nai	ls so long they were					
	upturned. Staff	(direct care staff) said					
	that she (client A) has an appointment						
	with the podiatri	st once in every six					
	months but the g	guardian does not have					
	any records of a	podiatry appointment.					
	Plan to Resolve:	Agency will take					
	immediate safety	y measures to ensure					
	[client A's] healt	h and safety."					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			00	(X3) DATE : COMPL	
		15G464		LDING		04/18/	
			B. WIN		ADDRESS CITY STATE 7IB CORE	J :: 13/	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			LLVILLE, IN 46410		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The Carilla In						
	_	ords were further 6/12 at 10:10 A.M The					
	· · ·	ative report of the					
		report indicated the					
		estigation was conducted					
	' ' '	All staff was (sic.)					
		oved from the home					
	1	Its of the investigation					
		staff trained and put into					
	_	e. The results of the					
		as follows: [Client A's]					
	l • `	ho are co-guardians of					
		ctures on Sunday March					
	l '	pm of a mark on [client					
	`	the facility) received					
		n Monday March 26,					
		via email. Two separate					
		sments were performed					
	•	ne Director of Health					
	Services-RN. Bo	oth nurses stated in the					
	_	l upon follow-up with the					
	department head	that there was no					
	swelling of the h	ands noticed, nor was a					
	bruise noted on [client A's] abdomen.					
	The only skin dis	scoloration noted was an					
	approximate dim	e size very light pink					
	area to her (clien	t A's) lower buttock.					
	[Client A] was th	nen assessed by the					
	doctor. The doct	or did not notice any					
		ng at the time of visit.					
	l -	res of long toe nails and					
	_	were also included. The					
	1 -	t A's] toe nails and					
	<u> </u>						<u> </u>

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	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION (IDENTIFICATION NUMBER: 15G464	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/18/2012				
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2414 WOODLANE MERRILLVILLE, IN 46410						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION				
	cleaned her finger nails at about 8:30 pm on Sunday 3/25/12. Risk plans will also be in place for care of nails for the consumer. The investigation was concluded and the allegation substantiated. Discipline was rendered, four staff had direct knowledge of [client A's] toe nails and their employment at the [Agency] was terminated. The remaining staff did not work shifts which involved bathing or dressing and had no direct knowledge if the condition of [client A's] toe nails or the pink dime size mark but will receive additional training in regards to client needs and care. New staff are in place and being trained to work with [client A.] [Client A] also visited a podiatrist whom indicated that there was no damage caused by [client A's] feet from her long toe nails." The facility's records were further reviewed on 4/16/12 at 10:22 A.M Evidence from the 3/30/12 investigation indicated photographs of client A's body, which were taken by client A's guardian on 3/25/12 and forwarded to the facility. Review of the photographs indicated dirt under client A's fingernails which was determined to be feces. Client A's toe nails were noted to be of varied length from one-half inch to an inch and were upturned. A dime size pink mark was noted on client A's buttocks and a pencil							

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G464			A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL 04/18/	ETED
	PROVIDER OR SUPPLIER		B. WIN	STREET A	OODLANE LVILLE, IN 46410		
(X4) ID	NORTHWEST IND	TATEMENT OF DEFICIENCIES		ID	<u> </u>		(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
		blue blood blister was					
	4/16/12 at 10:31 evidentiary docu direct care staff of incident did not of client A's toe nair and did not conscient's finger na Further review in did not immediate pink mark on client's finger to administrator. A indicated client of facility's Service Mental Health Promorning of 3/25/2 length of client of pink mark, and promoted and feces under the Review of the Service Coordinate action to have client's buttoo the client's buttoo	were further reviewed on A.M Review of mentation indicated working at the time of the consider the length of ls to be of excess length ider the dirt under the ils to be "uncommon." indicated direct care staff tely report the dime size ent A's buttocks and the e blood blister on the the facility's idditional review A's family told the Coordinator (Qualified rofessional) on the 12 of the excessive A's toe nails, dime size encil size blood blister, the client's fingernails. ervice Coordinator's erview indicated the ator did not take any ient A's toe nails trimmed it the noted pink mark on eks or the blood blister ager to the administrator by the facility's					

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	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G464	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	e survey pleted 8/2012		
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2414 WOODLANE MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	Nurse #1 was interviewed on 4/17/12 at 9:12 A.M Nurse #1 stated client A's toe nails "were so long that she (client A) curled her toes down so she could wear her shoes."						
	Program Director #1 was interviewed on 4/17/12 at 9:15 A.M Program Director #1 stated, "Four direct care staff and the Service Coordinator were found guilty of neglect and where terminated." Program Director #1 stated direct care staff "should have reported the pink mark and the blood blister immediately to the administrator."						
	The facility's records were further reviewed on 4/18/12 at 9:14 A.M A review of the facility's "Policy for handling Cases of Neglect and Abuse", dated 12/20/06, indicated, in part, the following: "I. [The Agency] prohibits all abuse, neglect and exploitation of our clients. II. Staff will immediately report any allegations of abuse, neglect or exploitation of our clients per agency reporting procedure. [The Agency] will meet current regulatory requirements for reporting all incidents. III. All allegations of abuse, neglect, humiliation or exploitation will be investigated per [The Agency] investigation process." The policy further indicated, "Neglect- is defined as knowingly placing a client in a						

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	OF CORRECTION OF CORRECTION 15G464	(X2) MULTIPLE CC A. BUILDING B. WING	00	— COM 04/1	e survey pleted 8/2012		
ARC OF	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2414 WOODLANE MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	situation that poses a threat to his/her health and well-being. Examples include, but are not limited to, depriving a client of food, clothing, shelter or medical care; not providing adequate personal care, leaving clients unsupervised, etc." This federal tag relates to complaint #IN00106203. 9-3-2(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLETED	
		15G464	B. WING			04/18/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				OODLANE		
ARC OF	NORTHWEST INDI	ANA INC, THE			LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
PREFIX	REGULATORY OR 483.420(d)(2) STAFF TREATM The facility must mistreatment, ne injuries of unknow immediately to the officials in accord established proce Based on record facility failed to or reviewed incident origin involving (client A), were in the administrator Findings include A review of the from 4/16/12 at 9:5 4/16/12, indicate of neglect which "Date: 3/26/2012 Narrative: [Client Client A] on 3/25 bruises on her (cli under her fingerr skin; and toe nail upturned. Staff (that she (client A)	MENT OF CLIENTS ensure that all allegations of eglect or abuse, as well as wn source, are reported to eadministrator or to other dance with State law through edures. review and interview, the ensure, for 1 of 1 at of injuries of unknown 1 of 3 sampled clients immediately reported to	Wo	PREFIX TAG	Residential Program Director verview requirements of abuse, neglect and exploitation of clie with Service Coordinators and DSPs and document this review ith regards to the 24 hour requirement. To ensure future compliance, the Service Coordinator, with the assistance of the Residential Program Director, will review all incident reports for this facility for one month to assess need for reporting and periodically thereafter.	vill nts w	COMPLETION
ı	_	uardian does not have					
	any records of a	podiatry appointment.					
	Plan to Resolve:	Agency will take					
		measures to ensure					
	[client A's] healtl						
<u> </u>	[cheft A 8] ficalti	n and saicty.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G464			A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL 04/18/	ETED
		100101	B. WIN		DDRESS, CITY, STATE, ZIP CODE	0 17 107	2012
NAME OF PR	OVIDER OR SUPPLIER				OODLANE		
ARC OF N	ORTHWEST INDI	ANA INC, THE	MERRILLVILLE, IN 46410				
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The facility's reco	ords were further					
	•	5/12 at 10:10 A.M The					
		ative report of the					
	-	report indicated the					
		stigation was conducted					
	by the agency. All staff was (sic.)						
	immediately removed from the home						
pending the results of the investigation							
and replacement staff trained and put into							
	•	e. The results of the					
	•	as follows: [Client A's]					
	family (sister's who are co-guardians of						
	• `	ctures on Sunday March					
	25, 2012 at 1:30 pm of a mark on [client						
		the facility) received					
		n Monday March 26,					
		via email. Two separate					
	•	sments were performed					
		ne Director of Health					
	•	oth nurses stated in the					
	investigation and	upon follow-up with the					
	department head	that there was no					
	swelling of the ha	ands noticed, nor was a					
	bruise noted on [client A's] abdomen.					
	The only skin dis	scoloration noted was an					
	approximate dim	e size very light pink					
	area to her (clien	t A's) lower buttock.					
	[Client A] was th	en assessed by the					
	doctor. The doct	or did not notice any					
	injuries or swelli	ng at the time of visit.					
	Additional pictur	res of long toe nails and					
	dirty finger nails	were also included. The					
	family cut [client	t A's] toe nails and					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	DNSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION		A. BUI	LDING	00	COMPL 04/18/	
		15G464	B. WIN			04/16/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
4DC OF	NODTI IMEGT INDI	ANA INC. THE			OODLANE		
	NORTHWEST INDI	ANA INC, THE		MERKII	LLVILLE, IN 46410		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
TAG				TAG	DEFICIENCE!		DATE
	_	er nails at about 8:30 pm					
	_	12. Risk plans will also					
		are of nails for the					
	consumer. The i	-					
	concluded and th	•					
		iscipline was rendered,					
		ect knowledge of [client					
	_	I their employment at the					
	1 2 2 2 2	rminated. The remaining					
		k shifts which involved					
bathing or dressing and had no direct							
	_	condition of [client A's]					
	_	ink dime size mark but					
		tional training in regards					
		nd care. New staff are in					
	_	rained to work with					
		nt A] also visited a					
	1 ^	indicated that there was					
	_	ed by [client A's] feet					
	from her long too	e nails."					
		1 0 1					
	1	ords were further					
		6/12 at 10:22 A.M					
		ne 3/30/12 investigation					
	,	raphs of client A's body,					
		n by client A's guardian					
		orwarded to the facility.					
		otographs indicated dirt					
		fingernails which was					
		feces. Client A's toe					
		to be of varied length					
		ch to an inch and were					
		ne size pink mark was					
	noted on client A	s buttocks and a pencil					
	-		-				-

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NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ARE BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2414 WOODLANE MERRILLVILLE, IN 46410 (X5)		OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO.	NSTRUCTION	COMPL	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE SUMMARY STATEMENT OF DEFICIENCIES TAG PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Facility records were further reviewed on 4/16/12 at 10:31 A.M Review of evidentiary documentation indicated direct care staff working at the time of the incident did not consider the length of client A's toe nails to be "uncommon." Further review indicated direct care staff did not immediately report the dime size pink mark on client A's family told the facility's service Coordinator (Qualified Mental Health Professional) on the morning of 3/25/12 of the excessive length of client A's toe nails, dime size pink mark, and pencil size blood blister, and feces under the client's fingernails. Review of the Service Coordinator did not take any	AND PLAIN	OF CORRECTION				00		
ARC OF NORTHWEST INDIANA INC, THE ARC OF NORTHWEST INDIANA INC, THE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY PULL. TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Facility records were further reviewed on 4/16/12 at 10:31 A.M Review of evidentiary documentation indicated direct care staff working at the time of the incident did not consider the length of client A's toe nails to be of excess length and did not consider the dirt under the client's finger nails to be "uncommon." Further review indicated direct care staff' did not immediately report the dime size pink mark on client A's buttocks and the pencil eraser size blood blister on the client's finger to the facility's administrator. Additional review indicated client A's family told the facility's Service Coordinator (Qualified Mental Health Professional) on the morning of 3/25/12 of the excessive length of client A's toe nails, dime size pink mark, and pencil size blood blister, and feces under the client's fingernails. Review of the Service Coordinator's investigative interview indicated the Service Coordinator did not take any			100101	B. WIN		PPPPGG GYMY GM :	U 4 / 10/	20 IZ
ARC OF NORTHWEST INDIANA INC, THE (X4) ID SUMMARY STATEMENT OF DEPCIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION) Fracility records were further reviewed on 4/16/12 at 10:31 A.M Review of evidentiary documentation indicated direct care staff working at the time of the incident did not consider the length of client A's toe nails to be of excess length and did not consider the dirt under the client's finger nails to be "uncommon." Further review indicated direct care staff did not immediately report the dime size pink mark on client A's buttocks and the pencil craser size blood blister on the client's finger to the facility's administrator. Additional review indicated client A's toe nails, dime size pink mark, and pencil size blood blister, and feces under the client's fingernails. Review of the Service Coordinator's investigative interview indicated the Service Coordinator did not take any	NAME OF P	PROVIDER OR SUPPLIER						
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) eraser size dark blue blood blister was noted on a fingernail. Facility records were further reviewed on 4/16/12 at 10:31 A.M Review of evidentiary documentation indicated direct care staff working at the time of the incident did not consider the length of client A's toe nails to be of excess length and did not consider the direct care staff did not immediately report the dime size pink mark on client A's buttocks and the pencil eraser size blood blister on the client's finger to the facility's administrator. Additional review indicated client A's toe nails to do the morning of 3/25/12 of the excessive length of client A's toe nails, dime size pink mark, and pencil size blood blister, and feecs under the client's fingernails. Review of the Service Coordinator's investigative interview indicated the Service Coordinator did not take any	ARC OF	NORTHWEST INDI	ANA INC, THE					
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and did not report the noted pink mark on the client's buttocks or the blood blister on the client's finger to the administrator until approached by the facility's administration on 3/27/12.		Facility records of 4/16/12 at 10:31 evidentiary document did not considered and did not considered from the client's finger national from the client's finger national from the client's finger national from the client's finger to a dministrator. A findicated client of administrator. A findicated client of facility's Service Mental Health Promorning of 3/25/length of client of pink mark, and pand feces under the Review of the Service Coordinate action to have client's findicated cli	were further reviewed on A.M Review of mentation indicated working at the time of the consider the length of ls to be of excess length ider the dirt under the ils to be "uncommon." indicated direct care staff rely report the dime size ent A's buttocks and the blood blister on the the facility's dditional review A's family told the Coordinator (Qualified rofessional) on the 12 of the excessive A's toe nails, dime size encil size blood blister, the client's fingernails. Ervice Coordinator's erview indicated the ator did not take any tent A's toe nails trimmed at the noted pink mark on each or the blood blister ager to the administrator by the facility's					

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	of Correction identification number: 15G464	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPL 04/18/	ETED		
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2414 WOODLANE MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE		
	Program Director #1 was interviewed on 4/17/12 at 9:15 A.M Program Director #1 stated, "Four direct care staff and the Service Coordinator were found guilty of neglect and where terminated." Program Director #1 stated direct care staff and the Service Coordinator "should have reported the pink mark and the blood blister immediately to the administrator." This federal tag relates to complaint #IN00106203. 9-3-2(a)						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A BUILDING 00		00	COMPLETED	
15G464			A. BUILDING			04/18/2012	
			B. WIN		ADDRESS CHEV STATE I'M CODE		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
					OODLANE		
ARC OF NORTHWEST INDIANA INC, THE				MERRILLVILLE, IN 46410			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES.)		TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	-	DATE
TAG W0159	483.430(a) QUALIFIED MEN PROFESSIONAL Each client's active integrated, consider a qualified mental Based on record revisited to assure the second integrated to a qualified to assure the second integrated to a qualified to assure the second integrated to a qualified to a second integrated to a qualified	NTAL RETARDATION	W0		A new Service Coordinator habeen assigned. Service Coordinator will be actively involved in treatment through daily review of logs, weekly vis and at least monthly review of data. To ensure future compliance, Service Coordina will make random unannounce visits to the home to review programming and to ensure clients' needs are being met.	sits, tor	05/01/2012

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PRINTED: 05/18/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED		
15G464		B. WING			04/18/	2012	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					OODLANE		
ARC OF NORTHWEST INDIANA INC, THE					LLVILLE, IN 46410		
(X4) ID	SUMMARY S	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORREC		ON (X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	_	s] body. We (the facility)					
	•	ures) on Monday March 26,					
	_	email. Two separate head to					
		re performed by the nurse &					
		th Services-RN. Both nurses					
		gation and upon follow-up with					
	*	I that there was no swelling of					
		or was a bruise noted on					
		n. The only skin discoloration					
		ximate dime size very light ent A's) lower buttock. [Client					
		d by the doctor. The doctor					
		njuries or swelling at the time					
		pictures of long toe nails and					
		ere also included. The family					
		nails and cleaned her finger					
		om on Sunday 3/25/12. Risk					
	_	place for care of nails for the					
	_	estigation was concluded and					
		antiated. Discipline was					
	rendered, four staff	had direct knowledge of					
	[client A's] toe nails	and their employment at					
	the[Agency] was ter	rminated. The remaining staff					
	did not work shifts which involved bathing or						
	dressing and had no direct knowledge of the						
	condition of [client A's] toe nails or the pink dime						
	size mark but will receive additional training in						
	regards to client needs and care. New staff are in						
	place and being trained to work with [client A.]						
	[Client A] also visited a podiatrist whom indicated						
	that there was no damage caused by [client A's]						
	feet from her long to	oe naiis."					
	The facility's record	a wara further raviewed an					
		s were further reviewed on M Evidence from the					
		n indicated photographs of					
	client A's body, which were taken by client A's guardian on 3/25/12 and forwarded to the facility. Review of the photographs indicated dirt under client A's fingernails which was determined to be feces. Client A's toe nails were noted to be of						
							<u> </u>

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AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G464		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMPI	(X3) DATE SURVEY COMPLETED 04/18/2012		
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 2414 WOODLANE MERRILLVILLE, IN 46410					
	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) varied length from one-half inch to an inch and were upturned. A dime size pink mark was noted on client A's buttocks and a pencil eraser size dark blue blood blister was noted on a fingernail. Facility records were further reviewed on 4/16/12 at 10:31 A.M Review of evidentiary documentation indicated client A's family told the facility's Service Coordinator (Qualified Mental Health Professional) on the morning of 3/25/12 of the excessive length of client A's toe nails, dime size pink mark, and pencil size blood blister, and feces under the client's fingernails. Review of the Service Coordinator's investigative interview indicated the Service Coordinator did not take any action to have client A's toe nails trimmed and did not report the noted pink mark on the client's buttocks or the blood blister on the client's finger to the administrator until approached by the facility's administration on 3/27/12. Program Director #1 was interviewed on 4/17/12 at 9:15 A.M Program Director #1 stated direct care staff and the Service Coordinator "should have provided appropriate care to [client A] and should have reported the pink mark and the blood blister immediately to the administrator. As an agency we train and re-train staff to take care of our clients in appropriate ways. We expect and trust them to do their jobs. It isn't always easy to		B. WIN	WING STREET ADDRESS, CITY, STATE, ZIP CODE 2414 WOODLANE		BE	(X5) COMPLETION DATE	
	determine when the This federal tag rela #IN00106203.	•						

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